Department of Labor and Industries - Claims Section
PO Box 44291, Olympia WA 98504-4291

Billing Code: 1069M

ACTIVITY PRESCRIPTION & WORK STATUS FORM

Gen Info			
	Injured Worker's Name:	Visit Date:	Claim Number:
	Doctor's Name:	DOI:	Diagnosis:

Treatment Plan

Treatment Plan:
- ☐ PT and/or OT is anticipated
- ☐ Other rehab (describe):
- ☐ Patient progressing as expected/better than expected
- ☐ Patient progress slower than expected (see chart notes):
- ☐ Estimated date of medical stability: _____/_____/_____

Which of the following were discussed with the injured worker:
- ☐ Expectations for rehabilitation and return to work
- ☐ Following restrictions at work and home
- ☐ Difference between hurt and harm
- ☐ Patient's responsibility in treatment plan
- ☐ Strategies for prevention of re-injury

Work Status

Returning to job of injury: When do you expect the patient to return to work?

☐ Patient is **released** to fully perform the job of injury on: _____/_____/_____ ☐ See **objective findings** in chart notes _____/_____/_____

☐ I **expect to release** this patient to the job of injury on: _____/_____/_____

Light / modified-duty work: *If the patient is unable to perform the job of injury*, can he/she perform modified-duty work (within tolerances identified below)?

☐ The patient **may work part-time**, _____ hours/day

☐ The patient may perform **modified-duty** from _____/_____/_____ to _____/_____/_____ _____ hours/day

Key Objective Finding(s) for modified duty or unable to return to work:

Unable to return to work: When do you expect the patient to return to work?

☐ I certify this patient is unable to perform the job of injury from ____/____/____ to ____/____/____

☐ Patient is **not expected to return** to the job of injury
If so, ☐ Patient is physically able to participate in vocational evaluation.

Contact with employer:
Employer contacted about return to work? Y N
Light duty available at workplace? Y N
Worker present during communication? Y N

Employer Contact: _____
Phone_____ Fax_____
Other Comments:

Estimate of Physical Capacities

POSTURE TOLERANCES *Good from ____/____/____ to ____/____/____*

	Never	Seldom 1-10%	Occas. 11-33%	Frequent 34-66%	Constant 67-100%
Sitting					
Standing/Walking					
Climbing					
Crawling					
Bending/Stooping					
Crouching/Squatting					
Kneeling					
Reaching					
Overhead Reaching					
Twisting					
Wrist (flexion/extension)					
Other_____					

REPETITIVE MOTION TOLERANCES Worker is able to use hands/feet for:

	Never	Seldom	Occas	Freq	Cont
Grasp (**L**eft, **R**ight, **B**oth)					
Fine Manipulation (**L**, **R**, **B**)					
Keyboarding					
Operate foot controls (**L**, **R**, **B**)					

MATERIAL HANDLING

	Never	Seldom	Occas.	Frequent	Const.
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift/Carry	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Push/Pull	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs

*Address overhead and floor lifts in **Posture Tolerances** or **Other Instructions***

OTHER RESTRICTIONS / ACTIVITIES
*If restricted, circle yes, and explain in **Other Instructions***

Unprotected heights	Y	N
Moving machinery	Y	N
Exposure to extreme temperature	Y	N
Driving automotive equipment	Y	N
Exposure to dust, fume, gases	Y	N

OTHER INSTRUCTIONS (e.g., no driving when taking medication, elevate leg 5 min every hour)**:**

Follow-up

FOLLOW-UP PLAN
- ☐ Next visit with this provider: _____
- ☐ Referral to/Consult with: _____
- ☐ Special studies: _____
- ☐ Other_____
- ☐ None. This is the last scheduled visit for this condition.

Any permanent partial disability? Y N *Are you willing to rate impairment?* Y N

Doctor/ARNP Signature:

PAC*:

Date:

I understand my term of time loss or work restrictions will expire on the dates noted above in the Work Status section, and can only be extended upon my return visit to the clinic.

Injured worker's signature:** Date:

*** PA-C's** must have the attending physician co-sign the APF for any situation other than a full release to the job of injury. PA-C's cannot certify time loss, including light/modified duty.
**** Note to IW and employer:** Follow physical capacity recommendations at work and outside of work. They are based on the doctor's best understanding of the employee's current medical condition and/or essential job functions. If a particular restriction does not apply, it should be disregarded. If light or modified duty that meets these tolerances is not available, the injured worker should be considered to be off work and the worker must notify the claim manager immediately. Failure to do so may affect the worker's benefits.

Instructions for Completing Activity Prescription & Work Status Form

Coordination of care is critical to the safe and effective return of injured workers to health and function. Your completion of this form will help to ensure that your patient receives necessary care in a timely manner.

Treatment Plan (for physical rehabilitation): Use the left side box to describe the physical treatment plan and the right side box to document the concepts discussed (talking points) with the injured worker.

Talking Points: Identification and communication of appropriate activity level enables the injured worker to resume activity as early as it is medically appropriate. *Early return to activity is correlated with reduced long term disability.* Check only those concepts discussed on the date the form was completed.

- Expectations for rehabilitation and return to work: Some patients or employers might have expectations of getting "paid time off" for the duration of a claim. Early return to normal activity has been shown to be far more beneficial than prolonged rest in recovering from common musculo-skeletal injuries, particularly low back conditions. Be sure to instruct worker on minimum levels of activity that will enhance rehabilitation.
- Following restrictions at work and home: Any instructions about restricting particular home or work activities, proper body mechanics, or referral to a specific exercise program (including regular walking).
- Difference Between Hurt and Harm. Check this box when you discuss the difference between temporary increased discomfort due to increased activity levels during the rehabilitation process and pain that indicates a more serious issue.
- Patient's Responsibility in Treatment Plan: Patient expectations, including understanding their role and responsibility in their own recovery, can play an important role in complying with treatment recommendations and return to work instructions.
- Strategies for prevention of injury: Instructions in any specific strategies or practices to prevent re-injury.

Work Status: Identify the injured worker's work status based on the effect of the accepted industrial injury/disease. Completion of this section is necessary so that the claim manager can determine if time loss compensation is payable. In all cases except a full release to work, *please provide at least one key objective finding* so that the claim manager will not have to wait for or request your office notes. Doing so will assist the claim manager in paying benefits in a timely manner. (Office or chart notes still need to be sent to L&I for claim management.)

Returning to the job of injury: Use this section to communicate the worker's ability to *fully* perform the job of injury. Any other recommendation, including part-time work, should be noted in the next section.

Light / modified-duty work: Use this section to communicate the worker's ability to perform modified-duty work (modified work processes or modified work equipment). Indicate how many hours per day, and how long the modified-duty status is in effect. Please provide at least one key objective finding.

Unable to return to work: Use this section to communicate that the worker is not currently able to return to work. *Please identify as soon as possible if you have any concern that the worker may be permanently restricted from returning to the job of injury.* Please provide at least one key objective finding.

Estimate of Physical Capacities: Use this section to detail the worker's current physical abilities, based on your medical estimate. This information will help the worker and the employer to identify appropriate lighter duty work activities. Completion of this section also enables vocational providers to identify potentially appropriate return-to-work options. If a particular tolerance does not apply to the patient you are seeing, please indicate "N/A" in that section.

Follow-up Plan: Use this section to identify your plans for follow-up and/or referral. Check any appropriate boxes and fill in the blanks when indicated. If additional diagnostic studies are necessary, indicate in the "special studies" section.

Sign and Date: The injured worker and the attending provider must sign and date this information. Doctors and ARNPs may complete, sign and bill for this form. *Physician Assistants must have the attending physician co-sign the form for any situation other than a full release to the job of injury.* PA-C's cannot certify time-off from the job of injury or light/modified duty. Please provide the injured worker with a copy of the form to take to the employer. Instructions to the injured worker are included beneath their signature box.

Submitting the form to the Department: The completed form may be faxed to any of the following fax numbers for the department. It can also be mailed to the address at the top of the form.

360-902-4566	360-902-4567	360-902-5230	360-902-6460
360-902-4292	360-902-4565	360-902-6252	360-902-6100

On receipt, the document is available for viewing by individuals with claim access. A message is also placed in the department's claim file notes to alert users that updated information has been received.